Basic Health™

Information to help you apply

Attached is your application for Basic Health, a reduced-cost health care program for eligible Washington State residents.

To use this application you must:

- Be over 18 years of age
- Have no dependents
- Not be pregnant or seeking maternity benefits
- Fall within the income limits (up to $1,733.41 for a family of 1, and up to $2,333.44 for a family of 2)
- Not be eligible for Medicare

If you are pregnant or have children, please visit www.basichealth.hca.wa.gov or call 1-800-660-9840 to receive the correct application.

Three Steps

Step 1: Complete and sign the application.

Be sure to send copies of documents that prove the information in your application. More detailed information is available online at **www.basichealth.hca.wa.gov**.

- ❑ Proof of Washington State Residency (Documents showing only a PO Box are not accepted)
  - Current utility bill showing your physical address
  - Washington State driver license or identification (ID) card
  - Rent or mortgage receipt
  - Current school registration
- ❑ Proof of Income
  - Pay stubs, or statement from employer for four consecutive weeks
  - Court orders, award letters, or other proof of payment from other sources including Social Security, Workers' Compensation, unemployment, retirement, and public assistance.
  - IRS Form 1040 and all schedules filed for the most current tax year or a statement if you are not required to file.

Step 2: Return the application.

Mail to: Basic Health, PO Box 94213, Seattle, WA 98124-6513
Fax to: 360-923-2910 or 360-923-2610

Step 3: Respond to requests for additional information.

Please respond quickly to requests for additional information so Basic Health can process your application.

Final Checklist

Please make sure you include the following when submitting your application:

- ❑ Documentation of full 30 days' income from all sources
- ❑ Current tax year 1040 form, including all schedules and K-1 form, if you received one, or a statement if not required to file.
- ❑ Documents showing your name and current street address
- ❑ Application signed by you and your spouse, if legally married
- ❑ Your health plan choice on the first page of the application
- ❑ The Permission Form (available at **www.basichealth.hca.wa.gov**) if you'd like someone else to be able to access your account information.
- ❑ If you are self-employed or have rental income, please request a reporting form (available at **www.basichealth.hca.wa.gov**) or call 1-800-660-9840.

For more information on Health Plans and Premiums, Benefits and Services, and pre-existing conditions, please view the Applying for Basic Health booklet at www.basichealth.hca.wa.gov or call 1-800-660-9840.

Basic Health™

Application - no dependents

NOTE **Use blue or black ink to complete this application. Your Social Security number (SSN) is voluntary. If you do not provide your SSN, we will assign an ID number to you. We depend on your SSN for verifying income with certain sources. If you do not provide your SSN, you will have to prove your eligibility for Basic Health more often.**

Section 1: Household Information

Complete this section for applicant and legal spouse, even if not requesting coverage.

What language and dialect do you speak?	Check here if you need an interpreter ☐		WA Driver License or ID Number	
Applicant's last name	First name	MI	Social Security number	Birth date
Gender ☐ Male ☐ Female	Requesting Coverage? ☐ Yes ☐ No	U.S. citizen? ☐ Yes ☐ No	Receiving DSHS Benefits? ☐ Yes ☐ No	
Street address required; **must attach proof**	Apt. #	City	County	State / ZIP Code
Mailing address or P.O. Box (if different from above)		City	County	State / ZIP Code
Home phone number ( )	Other phone number ( )	Marital status (check one) ☐ Single ☐ Legally Separated ☐ Legally Married – Date of marriage: _____		
Spouse's last name	First name	MI	Social Security number	Birth date
Gender ☐ Male ☐ Female	Requesting Coverage? ☐ Yes ☐ No	U.S. citizen? ☐ Yes ☐ No	Receiving DSHS Benefits? ☐ Yes ☐ No	

Are you or your spouse currently receiving Social Security disability benefits (SSDB)? ☐ Yes ☐ No
If "yes," list them here with dates benefits started. Attach copies of the original and current award letters for each.

Name _____ SSDB entitlement date _____

Are you or your spouse eligible for Medicare (the federal health program for people over age 65 or people who have been receiving Social Security disability benefits for more than two years)? ☐ Yes ☐ No **If "yes,"** list them here

Name _____ SSDB entitlement date _____

Was anyone on this application a member of the Washington National Guard or Reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle? ☐ Yes ☐ No **If yes,** send a copy of Form DD214 for priority enrollment.

Are you or your spouse attending school full time in the United States on a temporary student visa? ☐ Yes ☐ No

If "yes," list them here _____

Section 2: Health Plan Selection

CHOOSE ONE HEALTH PLAN FOR YOUR FAMILY *(CHECK ONE)*

Not all health plans are available in every county. Read the ***Applying for Basic Health*** booklet to see the plans available in the county where you live.

☐ **Columbia United Providers, Inc.** ☐ **Community Health Plan of Washington** ☐ **Group Health Cooperative** ☐ **Kaiser Permanente** ☐ **Molina Healthcare of Washington, Inc.**

TYPE OF COVERAGE *(CHECK ONE)*

☐ Individual/family coverage

☐ Coverage through a financial sponsor, employer, or home care agency

Employer/organization _____ Group ID number _____ Daytime phone number ( ) _____

Continued

Section 3: Family Income

Basic Health may average or use your last 30 days' income to get the most accurate picture of your income.

Family Income Reporting Form – Show gross amounts (before taxes) on this form.

Have you changed employers in the last 12 months? ☐ Yes ☐ No Has your income changed in the last 12 months? ☐ Yes ☐ No

Briefly explain change(s) _____

_____

If you have not received a full 30 current/consecutive days of income or benefits from any source of income you listed below, please explain why here.
Also explain any periods for which you don't have documentation. _____

_____

☐ **Check here if you are not required to file a tax return.**	**AMOUNT RECEIVED IN LAST 30 DAYS**	**WHICH FAMILY MEMBER(S) EARNS THIS INCOME?**
Gross wages, salary, tips, assistantships, commissions	$	
Self-employment or rental income Provide Washington State Unified Business Identifier (UBI) #_____ Check box if no UBI # ☐ (See the checklist for details on what to send Basic Health.)	$	
Unemployment compensation, strike benefits	$	
Social Security benefits - check types received ☐ Retirement ☐ Survivor ☐ Supplemental security (SSI) ☐ Disability If Social Security disability, date of entitlement _____	$	
Retirements, pensions, annuity benefits Is the amount received due to an early withdrawal? ☐ Yes ☐ No	$	
Alimony/spousal maintenance received	$	
Insurance benefits, whether private or through employment, such as life, accident, long- or short-term disability	$	
Interest, dividends, trust, estate, inheritance, capital gains, gambling, lottery, royalties	$	
Veterans benefits, military allotments	$	
Workers' compensation	$	
Public assistance cash grants DO NOT INCLUDE FOOD STAMPS	$	
Income from any other source Explain _____ _____	$	

Section 4: Agreement and Signature

I understand that:

- I must provide proof of my family's gross income (before taxes and deductions) and report income changes that would change my premium or eligibility to Basic Health within 30 days after the end of the month my income changed.
- By signing this form, I have authorized Basic Health to verify my eligibility information and family income with other state or federal agencies or other third-party sources.
- I must report address changes and changes in my family. I must report, for example, my marriage or divorce, the marriage or divorce of any family member on my account, or the birth or adoption of a child.
- Basic Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.

I authorize my health plan or medical provider to give medical records for me to Basic Health, for purposes of participation in Basic Health.

I have read and I understand the information provided to me with the Basic Health application. I declare, under penalty of perjury, that the information I have given in this application and the documents I send to Basic Health are true, correct, and complete to the best of my knowledge. I understand that if I or any member of my family, or any person on my behalf, submits false information, my spouse or I may lose coverage, may be held financially responsible for services obtained under Basic Health or additional or past premium amounts due, and may face other penalties and prosecution. Any debt owed to the state may be sent to a collection agency for recovery.

Agreement must be signed by you and your spouse, if legally married

_____ _____ _____ _____

Signature of applicant Date Signature of spouse Date

All required forms and documentation must be mailed to:

Basic Health, P.O. Box 94213 Seattle WA 98124-6513
or FAX 360-923-2910 or 360-923-2610

Questions?

www.basichealth.hca.wa.gov
or call 1-800-660-9840

Privacy statement We will keep your information private as allowed by law.
The Washington State Health Care Authority runs Basic Health. To see our Privacy Notice, go to **www.hca.wa.gov** or call 360-923-2822.